

# Louisiana Wing Cadet Programs



## Encampment Application

### PRINT IN CAPITAL LETTERS

Complete the following pages as completely and accurately as possible. Illegible or incomplete applications will be returned to the Squadron Commander.

NAME (Last, First, MI)				JOINED CAP (MM/YY)		<b>OFFICE USE ONLY</b>  DATE RECEIVED: _____  PAYMENT: _____  FORMS: _____  <input type="checkbox"/> Payment <input type="checkbox"/> Application <input type="checkbox"/> Hold Harmless  TELEPHONE:  HOME: (    ) _____  OTHER: (    ) _____
CAPID	CAP GRADE	CHARTER O _____	REGION SW	STATE LA		
MAILING ADDRESS (Number and Street)						
(City)		(State)	(Zip Code)			
DATE OF BIRTH (MM/DD/YY)	HEIGHT	WEIGHT	GENDER	HAIR	EYES	
RELIGIOUS PREFERENCE	E-MAIL ADDRESS					
<b>SOCIAL SECURITY NUMBER - <u>MANDATORY</u></b>						

Flight Member ☐

OR

Staff ☐

**Note: Prior Encampment completion is required for staff**

(Indicate Staff Position Desired ? )

1) \_\_\_\_\_

2) \_\_\_\_\_

T-Shirt \_\_\_\_\_ Small \_\_\_\_\_ Medium \_\_\_\_\_ XX-Large  
(Adult Sizes) \_\_\_\_\_ Large \_\_\_\_\_ X-Large \_\_\_\_\_ XXX-Large

### SQUADRON COMMANDER CERTIFICATION

I verify that I have reviewed this application with the applicant and that it is accurate to the best of my knowledge.

Name \_\_\_\_\_ Signature \_\_\_\_\_

**You must obtain all signatures as indicated. Witnesses for parent signatures may not be a member of CAP, and must be over the age of 21.  
Parents cannot witness each other's signatures!**

**Mail your completed application packet along with the appropriate fee to:**

**Louisiana Wing Summer Encampment  
4868 North Boulevard  
Baton Rouge, LA 70806-6804**

**Please make checks payable to Louisiana Wing, CAP**

**MEDICAL INFORMATION AND RELEASE FORM - TO BE COMPLETED BY ALL APPLICANTS**

*This information is for Official Use Only and will not be released to unauthorized persons. Answer all questions as accurately as possible so that encampment staff can make themselves aware of any pre-existing medical problems or conditions.*

NAME (Last, First, MI)

CAPID

DO YOU CURRENTLY USE ANY MEDICATION? (including eye drops or over the counter)

☐ NO☐ YES (List any medication taken and the reason in the remarks section)

SOCIAL SECURITY NUMBER

**PLEASE NOTE: Failure to fully disclose medications, prescription or over-the-counter, could result in dismissal from Encampment.**

ARE YOU ALLERGIC TO ANY MEDICATION?

☐ NO☐ YES (List any medication allergic to in the remarks section)

HAVE YOU HAD OR BEEN INVOLVED IN AN ACCIDENT IN THE PAST 2 YEARS?

☐ NO☐ YES (Explain the extent of your injuries and treatment required in the remarks section)

HAVE YOU HAD OR HAVE NOW ANY OF THE FOLLOWING? (If yes is answered on any item, please explain in the remarks section with dates and physician(s) consulted (if any). Items not specifically noted below having the potential to interfere with performance during encampment should be documented in the remarks section.)

☐ NO☐ YES Heat related illness☐ NO☐ YES High or Low blood pressure☐ NO☐ YES Any known allergies☐ NO☐ YES Frequent or severe headaches☐ NO☐ YES Stomach trouble☐ NO☐ YES Chronic or recurring injuries☐ NO☐ YES Dizziness or fainting spells☐ NO☐ YES Asthma☐ NO☐ YES Chronic diseases like Diabetes, Bronchitis☐ NO☐ YES Unconsciousness for any reason☐ NO☐ YES Ear infections☐ NO☐ YES Females only - Menstrual cramps☐ NO☐ YES Eye trouble, excluding glasses☐ NO☐ YES Epilepsy or seizures☐ NO☐ YES Other illness or accidents☐ NO☐ YES Hay fever☐ NO☐ YES Kidney stones or blood in urine☐ NO☐ YES Admission to hospital☐ NO☐ YES Sugar or albumin in urine☐ NO☐ YES Motion sickness☐ NO☐ YES Attempted Suicide☐ NO☐ YES Heart trouble☐ NO☐ YES Nervous trouble of any sort☐ NO☐ YES Medical treatment within the past 5 years other than regular office visits or physicals

FAMILY PHYSICIAN (Name, address, and phone number)

**INSURANCE INFORMATION**

Medical Insurance Plan

Company

Policy Number and/or Group Number

**MANDATORY**

EMERGENCY CONTACT - PARENT, GUARDIAN, OR CLOSEST RELATIVE TO BE NOTIFIED IN THE CASE OF EMERGENCY

Name

Relationship

Address

Day Telephone

Night Telephone

REMARKS AND/OR ADDITIONAL INFORMATION

I, \_\_\_\_\_

☐

being the parent(s) of the above described person

☐

being the legal guardian of the above described person

hereby give full authorization to any Medical Doctor, Medical Clinic and/or Hospital to administer emergency medical services to the above described person. This authorization is only valid on Civil Air Patrol activities. Additionally, my child may be given over-the-counter medications as deemed necessary by qualified Encampment Medical Personnel.

SIGNED \_\_\_\_\_

DATE \_\_\_\_\_

## **RELEASE INDEMNIFICATION AND HOLD HARMLESS AGREEMENT**

In consideration of being allowed to participate in a Civil Air Patrol Encampment at Barksdale AFB, Louisiana on 9 - 19 June 2005, and sponsored by the United States Air Force, I hereby agree to assume full responsibility for my own safety and indemnity, save and hold harmless the Government of the United States and of its employees and agents, acting officially or otherwise, from any and all liability, claims, demands, actions, debts, and attorney fees arising out of, claimed on account of, or in any manner predicated on a loss or damage to the property of and injuries to, or death of any persons whatsoever, which may occur resulting from my presence within the limits of Barksdale AFB in connection with the aforesaid program, do hereby waive forever any demands or claims thereof.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Printed Name of Participant

### **Parent or legal guardian must sign for all participants under the age of 18**

Address	
Home Phone	Work Phone
Cell Phone	Any Additional Contact Information

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Printed Name of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness to Parent/Guardian Signature

\_\_\_\_\_  
Printed Name of Witness

**You must obtain all signatures as indicated. Witnesses for parent signatures may not be a member of CAP, and must be over the age of 21.  
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